[redacted] Age: 44 November 29, 1932

C.C. Lead Poisoning

P.I. February 1932 started work on molten lead spraying operation which consisted of oxy-acetylene torch through which was fed a lead wire under pressure so that the torch would project a spray of finely divided molten lead on objects to be coated. Work was done in booth and patient wore a cone respirator the sponge of which was changed twice daily. Great care was exercised in point of cleanliness - changec clothes and washed before eating or leaving work - did not eat or chew tobacco while at work. The booth (3x2x5 ft) was equipped with a fan which was in constant operation during the working hours and was considered adequate for air changing in booth. Such amounts of SO_2, NH_3, and HCL(soldering as escaped into the air of the main room would be sucked out throu the main ventilating apparatus as well as through the patient's hood and 3 others which were in operatinn in this area. Enclosed area (main room) is situated in the corner of the building and comprises an area of approximately 50 x 50 feet. On an average, once per week, escaping NH_3 was sufficiently concentrated to drive all 12 men out of the area.

Patient worked under these conditions for about 3 months till May 1932. During which time his health gradually became poor. A sweetish metallic taste was constant after the first week of work and has persisted to date - somewhat better last month or two. After 3-4 weeks there began nervousness with restless sleep - frequent waking - following involuntary jerking movements of arms and legs during sleep - no bad dreams - no insomnia. At times during day would have to stop operation because of tremors and shaking involving entire muscular apparatus - no chill -
May 1932 - after bad spell of trembling - went to hospital where he was told he had a fever and was sent home where he remained in bed for 4 days - returned to work - worked 1/2 day - went home. Stayed one week. Taken off operation and put on testing operation (no exposure) About 2 weeks work in 2 months. Has had no work since July 1932.

Since July has had no improvement - taste in mouth persists - has periods of lassitude and nervousness - has generalized tremors. Appetite has been good - eats little lunch - no constipation at any time - occasional headaches. No unusual indigestion - no cramps or colic. Weakness and taste in mouth have been principal annoyances to date. Mouth felt very dry for first few months - at present has salivation especially noticeable on going out into air. No cough - no chills - no fever- (usual T.98.5-6). Weight loss 8-9 lbs last 9 months.

I. H. School till 21. Salesman 18 years (oxy-acetylene welding apparatus) Frigidaire past 5 years. Welder 9 months - foreman welder 3 years - Silver solderer 2 months - then on present operation.

Pb. H. Only on present spray operation. No Hg exposure.

P. H. Born Philadelphia - 2 years - Eupope till 1908 - U. S. A. since- Traveled considerably as salesman - never in Tropics.

F. H. Father died at 58 - diabetes. Mother died 80 years - 2 sisters living and well. Wife living and well. 2 children living and well. No miscarriages.

H. I. Influenza 1931 - 2 weeks - questionable illness 1922 - bed 1 month.

C. R. Dyspnoea on exertion past 9 months. 2 Attacks severe asthma at night April 1932. Wheezed most of night - whitish sputum.

G. I. Hemorrhoids - symptomless.

G. U. Negative

N. M. Occasional headaches - after nervous spells has cold sensation in hands - no numbness - tingling or formication.

Best weight 165 (1914) - lowest 138 (1931) - present 145.

Habits Averages 8-9 hours sleep - no alcohol past 2 years. Little tobacco.

Mental Increased irritability - memory recent events somewhat poor. Noticeable impairment eyesight past year.

PHYSICAL

Dark complectioned - spare built white man about 40 years old - not acutely ill. Anxious expression - alert - cooperative - judgment good.

T: 98.2 P: 72 R: 20 B.P. 121/88

Head negative

Ears negative

Eyes R-L med. regular. Reflexes P.O.R. O.K. convergence good.

Nose Small amount mucoid discharge on left.

Mouth 8 snags - 3 bad - 1 crown
Gums good - no line.
Tongue coated. Mucous membrane clear
Tonsils very small - scarred - reddened - anterior pillars injected.

Neck negative

Chest K.I. Rt.6.0 Lt.9.0 D.E. Rt. 3.5) Lt. 3.5) normal position R.S.D. 7.0 H.C.D. 2.5 x 11.5

Some increased normal difference in percussion note two sides especially right apex anteriorly. Expansion not greatly impaired. Tactile fremitus normal - whispered voice and breath sounds normal Spoken voice increased right apex -
Chest essentially negative.
Heart tones clear regular - apex rate 76. Reaction good.

Skin — Clear - thin - pale. Slight cutaneous edema - healthy otherwise. Bilateral palmar eczemia

Belly — Scaphoid - resp. excursions free. Muscle lax. There is an indefinite mass in R.L. Q. in area of diagram tender on deep palpation or forceful percussion. Nodes at Ponpart log are large as are inguinal nodes - most marked on right where they are tender.

Liver and spleen not palpable. Left Kidney not palpable.

Nodes — Other than inguinal and iliac are not palpable.

Reflexes — Normal ++ K.K. +++ - superficial normal - moderate myotactic irritability. Sensorium normal - acute.

Pelvis — Large sac with impulse on right - rings lax

Rectal — Several tags external hemorrhoids - also few internal - Prostate large - firm - especially left lobe which with the median is quite tender.

LABORATORY

WBC - 6,350 — Stipeling - 0
RBC - 5,290,000 — Hb - 15 H.H.

Diff. Poly 62.5 - L. 31.5 — M and T: 1 E: 5

Urine - Acid H.H. - Alb. negative — Sugar negative

Stool -

IMPRESSION

1. No evidence Plumbism
2. Dental caries and infection
3. Chronic tonsillitis
4. Prostatitis
5. Unexplained tumor in abdominal cavity.

[redacted]

RECOMMENDATIONS

1. Sample urine and faeces for lead
2. Surgical consultation on abdomen after B.E.
3. Dental X-ray - certain extraction snags.
4. G. U. examination
5. E and T. consultation.

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